

503 KENSINGTON AVENUE BUFFALO, NY 14214

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Scott J. Zimmerman, DrPH, MPH, Director **BILLING INFORMATION** PATIENT INFORMATION **ECDOH PROGRAMS** (Select Primary Reason for Testing) ☐ REFUGEE ASSESS (Q) **INSURANCE COMPANY NAME** NAME □ STD PATIENT ID NUMBER **INSURANCE ADDRESS** □ TB (TB) **ADDRESS** CITY STATE ZIP CITY STATE COUNTY ZIP POLICY NUMBER DATE OF BIRTH PATIENT SEX **RESPONSIBLE PARTY ADDRESS** TELEPHONE **GUARDIAN NAME** DIAGNOSIS (ICD9 DIAGNOSIS CODE) (Must PATIENT RACE (Please circle) be provided) 1-White 2-Black 3-Native American 4-Asian 5-Other 6-Hispanic 9 Unknown MEDICAID# PROVIDER NAME/LICENSE NO. PHYSICIAN SIGNATURE (Required for all Medicaid Patients) **FACILITY NAME** REPORTS MAILED TO ADDRESS ADDRESS SPECIMEN/SOURCE: (Check all that apply) DATE & TIME COLLECTED______ STAFF CODE □BLOOD,FINGERSTICK **□FECES** □THROAT □VAGINAL □BLOOD.VENIPUNCTURE □ORAL FLUID □URETHRAL □OTHER □RECTAL □CERVICAL □URINE LABORATORY TESTS: **BACTERIOLOGY** CLINICAL CHEMISTRY DIAG. IMMUNOLOGY ☐Hepatitis B Surface Ab □Culture-GC □Alkaline phosphatase $\square ALT$ □Hepatitis B Surface Ag □Culture-Enteric screen □AST ☐Hepatitis C Ab □HIV-1 & 2 Ab (signature □Bilirubin, total required below) □HSV-2 (gG2) IgG □NAAT:Ct.& GC

SPECIAL REQUESTS/ADDITIONAL INFORMATION:_

□Syphilis Ab